Mass General Brigham
Health Plan

Acne-Rosacea
Effective 01/01/2022

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☒ Prior Authorization ☒ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit (NLX)		
Specialty Limitations	This medication has been designated specialty and must be filled at a contracted specialty pharmacy.		
Contact Information	**Specialty Medications**		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions			

Overview
Prescriptions that meet the initial step therapy requirements will adjudicate automatically at the point of sale. If the prescription does not meet the initial step therapy requirements, the prescription will deny with a message indicating that prior authorization (PA) is required. Refer to the criteria below and submit a PA request for the members who do not meet the initial step therapy requirements at the point of sale.

Initial Step-Therapy Requirements:
First-Line: Medications listed on first-line are covered without prior-authorization.
Second-Line: Second-line medications will pay if the member has filled at least two different first-line medications or a second-line medication within the past 180 days.

Coverage Guidelines

	FIRST-LINE	SECOND-LINE
Medications for Acne Vulgaris	**Topical Anti-infectives:** OTC benzoyl peroxide Generic benzoyl peroxide (various formulations) Generic clindamycin 1% Generic erythromycin 2% Generic sulfacetamide 10% & sulfur 5% Generic sulfacetamide 10% ****Topical Retinoids:** Generic tretinoin cream (0.05% & 0.1%)	**Topical Anti-infectives:** Aczone (dapsone) 7.5% gel Dapsone 5% gel **Topical Retinoids:** Atralin (tretinoin) 0.05% gel adapalene 0.3% gel (RX) adapalene 0.1% cream (RX) Differin (adapalene) 0.1% lotion Tazarotene 0.1% cream Tazorac (tazarotene) 0.05% cream

	FIRST-LINE	SECOND-LINE
	Generic tretinoin gel (0.01%, 0.025% & 0.1%) Differin OTC (adapalene) 0.1% Gel	Tazorac (tazarotene) 0.05% & 0.1% gel tretinoin microsphere 0.04%, 0.1% gel Fabior (tazarotene) 0.1% aerosol foam
Medications for Acne Rosacea	Generic metronidazole 0.75% cream, gel, lotion	metronidazole 1% gel Noritate (metronidazole) 1% cream azelaic acid 15% gel Ivermectin (Soolantra) 1% cream

If a member does not meet the initial step therapy requirements, then approval of a second-line medication will be granted if the member meets the following criteria:

Aczone 7.5% gel & dapsone 5% gel

1. Patient must have a diagnosis of acne vulgaris (comedonal acne, cystic acne, etc.) or rosacea **AND**
2. Patient has had a documented inadequate response, side effect, or allergy to at least two (2) different generic topical anti-infective agents used separately or together (i.e., clindamycin, erythromycin, benzoyl peroxide, sulfacetamide, or sodium sulfacetamide/sulfur)

Atralin, adapalene 0.3% gel, adapalene 0.1% cream, Differin 0.1% lotion, tretinoin microsphere 0.04%, 0.1% gel

1. Patient must have a diagnosis of ichthyosis, hyperkeratosis, acne vulgaris (comedonal acne, cystic acne, etc.), or rosacea **AND**
2. Patient has had a documented inadequate response, side effect, or allergy to a *preferred* generic tretinoin cream or gel OR Differin OTC 0.1% gel.

Tazorac cream/gel 0.05%, Tazorac 0.1% gel, tazarotene 0.1% cream & Fabior foam

1. Patient must have a diagnosis of plaque psoriasis **OR**
2. Patient must have a diagnosis of acne vulgaris (comedonal acne, cystic acne, etc.), or rosacea **AND**
3. Patient has had a documented inadequate response, side effect, or allergy to a *preferred* generic tretinoin cream or gel OR Differin OTC 0.1% gel.

Azelaic acid 15% Gel, metronidazole 1% and ivermectin 1%

1. Patient must have a diagnosis of rosacea **AND**
2. Patient has had a documented inadequate response, side effect, or allergy to generic metronidazole 0.75% gel, lotion, or cream

Limitations

1. Initial approvals and reauthorizations will be granted for 12 months.
2. All prescriptions for topical Retinoids will require PA for members 26 years of age and older.

References

1. Benzoyl peroxide) [prescribing information]. Scottsdale, AZ: ProGen Inc.; received February 2017.
2. Erygel (erythromycin) [prescribing information]. Newtown, PA: Prestium Pharma; August 2015
3. Plexion (sodium sulfacetamide/sulfur) cleanser [prescribing information]. Houston, TX: Brava Pharmaceuticals LLC; January 2014

4. Ovace Plus (sulfacetamide) foam [prescribing information]. San Antonio, TX: Mission Pharmacal Co; January 2015.
5. Altreno (tretinoin) [prescribing information]. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC; August 2018.
6. Differin Gel 0.1% (adapalene) [prescribing information]. Fort Worth, TX: Galderma; June 2018.
7. Aczone 5% Gel (dapsone) [prescribing information]. Irvine, CA: Allergan; May 2018.:
8. Avita (tretinoin) gel [prescribing information]. Morgantown, WV: Mylan Pharmaceuticals; January 2018.
9. Differin Gel 0.3% (adapalene) [prescribing information]. Fort Worth, TX: Galderma; December 2013.
10. Differin Lotion (adapalene) [prescribing information]. Fort Worth, TX: Galderma; April 2013.
11. Tazorac cream (tazarotene) [prescribing information]. Irvine, CA: Allergan, Inc; July 2017
12. Tazorac gel (tazarotene) [prescribing information]. Irvine, CA: Allergan, Inc; April 2018.
13. Flagyl Cream (metronidazole) [product monograph]. Laval, Quebec, Canada: Sanofi-Aventis Canada Inc; August 2018.
14. MetroLotion (metronidazole) [prescribing information]. Fort Worth, TX: Galderma Laboratories; February 2017.
15. Metronidazole gel [prescribing information]. Bridgewater, NJ: Valeant; March 2014
16. Noritate (metronidazole) 1% cream [prescribing information]. Bridgewater, NJ: Valeant; March 2018.
17. Finacea (azelaic acid) gel [prescribing information]. Whippany, NJ: Bayer HealthCare Pharmaceuticals; August 2018
18. Ivermectin (Soolantra) (ivermectin) [prescribing information]. Fort Worth, TX: Galderma Laboratories, L.P.; April 2018.
19. Wolf JE Jr, Kerrouche N, Arsonnaud S. Efficacy and safety of once-daily metronidazole 1% gel compared with twice-daily azelaic acid 15% gel in the treatment of rosacea. Cutis 2006; 77:3.
20. Conde JF, Yelverton CB, Balkrishnan R, et al. Managing rosacea: a review of the use of metronidazole alone and in combination with oral antibiotics. J Drugs Dermatol 2007; 6:495.
21. Webster GF, Berson D, Stein LF, et al. Efficacy and tolerability of once-daily tazarotene 0.1% gel versus once-daily tretinoin 0.025% gel in the treatment of facial acne vulgaris: a randomized trial. Cutis 2001; 67:4.

Review History

03/21/05 – Reviewed
02/27/06 – Updated
03/05/07 – Updated
12/20/07 – Updated
010/3/08 – Updated
02/25/08 – Updated
02/23/09 – Updated
09/02/09 – Avita note
02/22/10 – Updated
06/18/10 – Adapalene gel
07/23/10 – Adapalene cr
08/02/10 – Tretin-x
02/28/11 – Reviewed
02/27/12 – Reviewed
02/25/13 – Approvable dx question
04/08/13 – Updated
07/29/13 – Updated
08/26/13 – Updated
10/21/13 – Updated

11/04/13 – Updated
01/13/14 – Retin-A micro gel & Metrogel 1% generics
02/24/14 – Updated
05/05/14 – Differin generic
02/23/15 – Reviewed
09/18/17 – Updated
02/26/18 – Updated
02/20/19 – Updated
07/2019 – Removed references to Finacea foam (nonformulary)
11/18/2020- Removed references to Azelex; removed Azelex from ST criteria to NF for 1/1/2021 strategy for Comm/Exch. Separated out criteria for MH vs. Comm/Exch
11/17/2021- Reviewed and Updated; added Tazorac 0.1% gel to Coverage requirements. Effective 01/01/2022.